Testimony to the Appropriations Committee

Presented by Mag Morelli, President
of LeadingAge Connecticut

March 3, 2021

House Bill 6439, An Act Concerning the State Budget for The Biennium Ending June Thirtieth, 2023, and Making Appropriations Therefor

Value Aging – Invest in Quality

Senator Osten, Representative Walker, and members of the Appropriations Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing 130 not-for-profit provider organizations serving older adults across the continuum of aging services. Our members are all governed by community boards and they provide care, services and housing for approximately 12,000 older adults each day.

Thank you for this opportunity to testify on the Governor's budget proposal. While we have submitted written testimony on many topics related to aging services, I would like to focus my testimony today on the pending transition to an acuity-based nursing home Medicaid reimbursement system, the need to address the reimbursement rates for home and community-based aging services providers, and the proposed cut to the Medicaid Savings Program.

As you know, the Department of Social Services is currently developing a new acuity-based, case-mix nursing home reimbursement system designed to replace our current cost-based system. The new case-mix system will add an acuity-based component and one or more value-based performance incentives to the payment rates. The state originally had a target implementation date of July 1, 2020, but implementation was postponed due to the pandemic. It is now proposed in this budget to begin on July 1, 2021.

Our association has been supportive of the concept of an acuity-based reimbursement system, but our support has always been conditioned on several issues we would like to see addressed in the new system – **the most important of which is to fully fund the system before transitioning to the new model.**

Make no mistake about it, this will be a major change in the reimbursement system – a change that has the potential to significantly impact the financial landscape of the entire nursing home sector. And if the transition occurs in a budget neutral manner, as is planned, it unfortunately has the potential to devastate some homes financially. And right now, as nursing homes are facing increased financial distress as a result of the pandemic, it is not the time to make this change. We therefore respectfully request that we wait to make this transition.

As this new system is designed, it will be important for nursing home providers to work together with the state to ensure that quality, well-staffed nursing home care is not disrupted. Again, because of the pandemic, we were not able to meet with DSS on this issue for over a year and the association has not yet been able to view or study any of the reimbursement models. We could not tell you if the models will benefit or disadvantage our nursing home members because we have not yet had an opportunity to test or review them. And we are concerned that a proper review and assessment cannot be achieved by July 1.

I would like to note that we were very fortunate to have had a meeting on the new system just this week with DSS. The meeting was helpful and positive, but many unanswered questions remain. We do look forward to continuing the discussion.

Prior to the pandemic, when we anticipated an earlier transition, we had two priority requests to help us achieve a successful transition that would achieve the policy goals of this new acuity-based system. These priorities remain the same today.

First, we request that the Committee include additional funding in the budget to meet the anticipated funding needs of the new system. This would mean at the very least the additional funding that would fully fund the documented Medicaid allowable costs of the delivering nursing home care. Based on 2018 cost reports, we calculate that number to be $135 million dollars. In addition, additional appropriations would need to be dedicated to the base rates of the case mix system if the State Legislature raises the state's minimum staffing levels as these levels would need to be maintained by each nursing home, regardless of their acuity mix. Finally, we would request additional funding be added for the value-based performance incentives.

The new system will only meet its intended policy objectives if it is fully funded. Otherwise, the current funding, which is woefully inadequate, will merely be moved around and reallocated within the new rate system. We fear that without the system being fully funded, some quality nursing homes will be negatively affected by a reduction in their rates while others will not receive nearly enough funding to cover the cost of caring for higher acuity residents.

Second, we request that the Legislature remain apprised of the details as the new system is developed. We are hopeful that your attention to the process will help to ensure that the final system design will deliver the resources needed to provide consumer access to quality nursing home care, to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators. The Legislature will not have an ability to influence the design of the new system if the details are not revealed until after the legislative session has adjourned.

In our written testimony we have outlined several items we would like to see incorporated into the new system, including an opportunity for nursing homes to proactively request a reduction in licensed bed capacity and then have the new smaller bed count applied to their new calculated base rate. Since a low census can be detrimental to a home's rate calculation, we see offering the ability to reduce beds and to have that incorporated into a new base rate as an opportunity to incentivize voluntary bed reduction for homes with excess bed capacity. While we felt this was critical last year, it is even more important now as the overall census in our nursing home sector has fallen to under 75%.

Home and Community Based Services
We view the development of a new nursing home rate system through the lens of the state's long-term systems and supports rebalancing initiative. And while we need to address the changing demand for nursing home care on one end of the aging continuum, we also need to address the growing demand for home and community-based services on the other end. We believe we can address that growing demand by building and strengthening the home and community-based provider network by attracting quality providers into the field. Unfortunately, like nursing homes, current rates of reimbursement are much lower than the actual cost of providing the services and are a barrier to attracting new providers. We must address this issue.

The Department of Social Services is currently undertaking a study of the rate methodology used to establish the existing fee schedule for the home and community-based services provided through the Connecticut Home Care Program for Elders. This study is being conducted at the request of the Centers for Medicare and Medicaid Services (CMS). We urge the state to utilize the results of this study to update the current fee schedule by raising the rates to levels that will meet the cost of providing the services. We then propose that the state initiate an annual cost of living rate increase for these home and community-based services. This worthy investment will work to build a strong network of home and community-based providers that is needed to achieve a successfully rebalanced system of long-term services and supports.

Medicaid Savings Program
We oppose the Governor's proposal to add an asset test to the Medicaid Savings Program's (MSP) eligibility criteria because we fear that this change may not only cause some current participants to lose their coverage, but may also discourage other potentially eligible older adults from applying for this critical coverage. The MSP assists qualified persons with the Medicare Part B premiums, deductibles, co-pays and Part D drug costs. Assisting lower income Medicare recipients with these high costs can be the difference between their maintaining full health care coverage and their losing critical Medicare Part B and prescription drug coverage. This vital assistance for eligible older adults is critical to assisting seniors in living independently in their homes and seeking the medical care and drug therapy they need, before their conditions becomes acute or urgent. It seems penny wise and pound foolish to cut back eligibility for this successful.

We have provided more detailed written testimony, but our closing message is this. Please stay committed to the vision and progress we have made in the area of aging services and let us work together to provide a strong and balanced system of long-term services and supports.

Thank you for the opportunity to testify and I would be happy to answer any questions.

Respectfully submitted,

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LeadingAge Connecticut

Aging Services and the Global Pandemic

Last year the aging services and health care delivery systems in Connecticut and across the country were in the midst of positive transformational change when our progress was stopped short by a once in a century global pandemic. Prior to the pandemic, nursing homes, home and community-based providers, physicians and hospitals were successfully working together on health system and care delivery reform - and it was making a difference in peoples' lives. When normal life was abruptly interrupted by the current public health emergency, the provider community continued to work collaboratively to combat the deadly virus. We thrust all of our efforts into protecting and treating those in our care and partnered with the state in this battle. And we are continuing to do so.

For aging services, the pandemic began with an invisible enemy that targeted the very people we serve. Through resilience, rigid safety standards and creative problem-solving, Connecticut's aging services providers have endured and managed through this pandemic, and are beginning to emerge from it. While we are not out of the woods yet, the arrival of the vaccine shows the end is now in sight. We have renewed hope.

The pandemic has also unveiled many long-standing problems within our Medicaid system of long-term services and supports. Provider rates that are inadequate. Reimbursement systems that are underfunded. Infrastructure needs that have been ignored. And workforce needs that are growing. But with recognition of these problems, momentum for reform has been created. And we are eager to work together with policymakers to achieve that reform.

Value Aging – Invest in Quality
Increasing the Rates of Reimbursement for the Continuum of Aging Services

Quality aging services – whether they are provided in the community or in the nursing home – cannot be sustained without rates of reimbursement that cover the cost of care. Medicaid providers are struggling to serve the older adult Medicaid client under the current reimbursement system and many providers are finding it increasingly difficult to stay in the program altogether. To maintain a strong network of providers, the rates of reimbursement must be increased to sufficient levels. If not, we risk losing ground on the strides that have been made in transforming our Medicaid program and rebalancing our system of aging services and supports. We ask that the state stay committed to that transformational effort as our work intensifies and the older adults we serve become frailer, older, and in need of more care, not less.

Current rates of reimbursement are much lower than the actual cost of providing long-term services and supports and while the recent small rate increases were greatly appreciated, there is still a long way to catch up to the current cost of providing services. ***We urge the Committee to develop a plan to adequately reimburse providers of aging services as we prepare for the aging of the state's population.***

Impact of a Minimum Wage Increase and the Workforce Crisis

The minimum wage phase in to $15 an hour continues to impact all providers of aging services. As the minimum wage is increased, it raises the entire wage scale and increases the cost of corresponding benefits. As a result, we anticipate a continued and significant increase in our labor costs.

The impact is also becoming evident in the competition for a steady workforce. As other employment sectors increase their wage scale, the ability to recruit and retain employees within the aging services sector has become more difficult, causing more pressure on our wage scales and the growing demand for employees.

The workforce demand within aging services was already reaching a crisis level and now we anticipate that the influence of the Covid-19 pandemic will have a catastrophic impact on our ability to recruit and retain an aging services workforce. **We urge the State to include the aging services sector in their workforce development efforts.**

Nursing Home Rate History and the Transition to an Acuity-based, Case-Mix System

Connecticut's Medicaid program is aggressively pursuing a strategic rebalancing plan for long term services and supports and nursing homes are at the center. The state's rebalancing plan calls for nursing homes to realign their structures, redesign their environments and reduce their bed capacity while intensifying their work as those they care for become frailer, older, and in need of more care. But the state must recognize that while they anticipate the need for fewer nursing homes, ***they must invest in the nursing homes that will still be desperately needed by those who cannot be cared for at home.***

The Covid-19 pandemic has only exacerbated the long-standing problems of our Medicaid reimbursement system for nursing homes. Medicaid is the single most important public source of funding for nursing home care, but the fact is that current Medicaid rates do not meet the cost of providing this care. In fact, the average daily Medicaid rate that is paid to a nursing home is *significantly lower* than the cost of providing that care.

Connecticut's current Medicaid rate structure is outlined in statute and is based on a calculation of the state defined allowable costs of providing daily nursing home care – but the actual per diem rates paid are much lower than the calculated rates due to years of legislated rate freezes. In fact, recent rate analysis data available from DSS shows that the paid per diem rates in total fall an estimated $135 million short of the actual calculated rates. Individually, LeadingAge Connecticut nursing home members are experiencing large gaps between what the current rate system calculates and what the Medicaid rate system actually pays. (*Link to overview of Medicaid rate setting for nursing homes)*

Historically, the state counted on other payor sources within the nursing home to make up the difference in the cost of providing care for Medicaid covered residents and the Medicaid rate. But the amount received by other payor sources is shrinking. Prior to the pandemic, 70% of residents living in nursing homes counted on Medicaid to pay for their care, but now it **is 83**% as the overall census has dropped and the number of private pay residents and post-acute care Medicare funded residents has

dropped precipitously. The census recovery is predicted to be slow and for non-profit nursing homes, this is resulting in a cash flow crisis that cannot be met by fundraising and reserves.

Nursing homes have not had a *general* nursing home rate increase since 2012. That increase was the direct result of an increase to their nursing home provider tax (which is now $21.02 a day), and the following year nursing homes received a rate cut. The subsequent rate increases that were given in 2015, 2016, 2018, 2019, 2020 and 2021 were specifically directed to wage enhancement pass through and while 70% of nursing home costs are related to human resources, there are other cost centers such as heat, utilities, food and medical supplies. All the costs related to resident care increase year after year and beyond the control of the nursing home providers, but only those related to direct labor costs have been recognized by the most recent rate increases. ***We ask that the Legislature address the overall financial needs of our state's nursing homes by fully funding the current system and adding additional funding to meet any new staffing mandates. If the overall system's underfunding is not addressed before the transition to a new acuity/case-mix nursing home reimbursement system is implemented, the new system will not be able to operate as intended.*** *(Link to overview of new acuity-based system development.)*

Medicaid Nursing Facility Rate History

Rate Period	*Increase/Decrease*	*Cost Report Year*
1/1/05-6/30/05	1.0%	2000
7/1/05-6/30/06	14.0% (4.0% net - Rebase with Tax)	2003
7/1/06-6/30/07	3.0%	2003
7/1/07-6/30/08	2.9%	2003
7/1/08-6/30/09	0%	2003
7/1/09-6/30/10	0%	2007
7/1/10-6/30/11	0%	2007
7/1/11-6/30/12	3.7% (1.25% net w/Tax Increase)	2007
7/1/12-6/30/13	0.33% (.17% net w/Tax Increase)	2007
7/1/13-6/30/14	-0.273 (Decrease)	2011
7/1/14-6/30/15	0%	2011
7/1/15-6/30/16	$26 + 9 million wage/benefit enhancement	2011
7/1/16-6/30/17	0%	2011
1/1/17-6/30/17	6-month loss of fair rent component for some homes due to policy change	
7/1/17-6/30/18	0% (Rebasing of rates with 1.6% stop loss)	2016
11/1/18-6/30/19	2% (Directed toward wage & benefits)	2016
7/1/19-6/30/20	2% (Directed toward wage & benefits)	2018
10/1/20	1% (Directed toward wage & benefits)	2018
1/1/21	1% (Directed toward wage & benefits)	2018

Nursing Home Provider Tax

It is important to keep in mind that nursing homes are required to pay a nursing home bed tax at a rate of $21.02 per bed per day. The proceeds of this tax go toward funding of the entire Medicaid system of long-term services and supports, not just nursing home care, and must be paid even if the resident's Medicaid application is pending and there is no payer source for the bed. This is one more cost burden placed on nursing home providers.

Transitioning to an Acuity-based Case-mix Rate Reimbursement System

Public Act 15-5 (Section 394) allowed for the implementation of an acuity-based reimbursement system and the statute requires the Department of Social Services to consider recommendations from the nursing home industry when developing the methodology. The State is now developing the new system which formerly had a target implementation date of July 1, 2020. It will replace the current cost-based system.

Our association supports the *concept* of a modernized case-mix nursing home reimbursement rate system that will add an acuity-based component and value-based performance incentives to the payment rates. *This will be a major change to the reimbursement system and in normal times would potentially have a significant financial impact on the nursing home sector*. Now, as nursing homes are facing severe financial distress as a result of the pandemic, it is not the time to make this change. ***We therefore respectfully request that we wait to make this transition.***

We request that the following be addressed in the new cast mix acuity-based system:

1) **This new reimbursement system will only meet its intended objectives if it is fully funded**.
   - The current cost-based system has an annual funding shortfall estimated to be $135 million. This estimate is based on the State's own calculation of the rates utilizing what the State considers to be the allowable costs of providing care. This is because of the freezes and limited rate increases placed on the statutory rate structure over the years. While nursing homes have recently received rate increases for labor costs, they had not had a general rate increase since 2012. That increase was the direct result of an increase to the nursing home provider tax, and then the following year the rates were cut.

   - This new case-mix system is currently planned to be "budget neutral" - which automatically means it too will be underfunded, but by what level we do not yet know. Therefore, if we do not increase the current level of funding, the new system will not be allowed to work as designed and will not meet the stated objective of appropriately funding high acuity care. The current funding will just be reallocated within the system, but not at the rate levels needed. As a result, we fear that many quality nursing homes may be negatively affected by a reduction in their rates and others will not receive the funding necessary to cover the cost of caring for higher acuity residents.

   - Similarly, it will be essential that the performance incentive payments, which are a hallmark feature of the proposed case mix system, be funded with **additional appropriations.** Given the demonstrated underfunding now present in the system, we believe it would significantly undermine the very objective of quality improvement if incentive funds were diverted from existing underfunded resources.

   - Finally, additional appropriations would need to be added to the base rates of the case mix system if the Legislature raises the minimum staffing levels beyond what homes are currently staffing at - as these levels would need to be maintained by all homes regardless of the acuity mix.

2) **Even with a delayed implementation, the Legislature must remain involved as we may not know details of the new system until later this year.** The new system cannot be properly evaluated until such time as the model design and the rate calculations are revealed. Because of this uncertainty, we believe it is imperative that the Legislature be kept apprised of the development and details of the new system and that certain principles to be included in the final system.

3) **We are requesting the following information be made available** to ensure that the system design will deliver the resources needed to provide consumer access to quality nursing home care, an ability to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators:
    - A fiscal evaluation that identifies the level of funding needed to adequately fund the final case-mix rate system model so that it can achieve the intended policy initiatives and outcomes.
    - A facility-by-facility impact analysis so that nursing homes can anticipate and plan for the financial impact.
    - An access to care analysis to assure a sufficient supply of nursing facility beds and services will be available, including specialty services.

4) **We are requesting that the new system include:**
    - A provision to adequately reimburse for the costs of providing specialty long-term care for diagnoses or behaviors that may not be captured by traditional acuity measures. This would include the care of those living with dementia.
    - A provision for value-based performance incentives funded provided through the allocation of new appropriations, not withholds.
    - A rate differential for nursing facilities within Fairfield County.
    - Timely inflationary adjustments and periodic rebasing of the base rates.
    - A phased-in implementation schedule, including a stop-loss provision.
    - To incentivize voluntary bed reduction, the ability for nursing homes to proactively request a reduction in licensed bed size and to have the new smaller bed count be applied to a recalculation of their base rate.
    - Training on this new system for nursing facility staff.

5) Reducing Bed Capacity

One element of what we are asking for is the ability for nursing homes to reduce their bed capacity prior to or after the implementation of the new rate system. Nursing homes with low census are penalized in the base rate calculation and we were hoping that the ability for homes to right size their facilities and have a rate system that accommodates this would bring about thoughtful bed reduction.

Last year we proposed that a thoughtful bed reduction would not only facilitate the rebalancing effort, but would also help bring financial stability to the nursing home sector; allowing it to maintain a stable workforce and provide quality resident care – and that we would be better positioned to implement the new acuity-based rate system for nursing home reimbursement.

This year we are in the midst of a global pandemic that has caused great financial distress on the nursing home sector. The resulting drastic reduction in nursing home census is slow to recover. As a result, many nursing homes may need to permanently reduce their bed size in the coming months or year. We therefore would ask that the reimbursement system allow for the recalculation of the base rate at any time a nursing home voluntarily reduces their bed size. **This provision would allow for thoughtful planning throughout the recovery period and may enable nursing homes restructure their nursing home service models.**

Residential Care Homes

The residential care home setting is both supportive and affordable and is a setting of choice for many older adults. It can be a valuable community-based housing choice for those choosing to receive Medicaid funded home and community-based services and supports and therefore we are currently working with the state agencies to ensure that residential care homes can choose to qualify as a community-based setting for the purpose of Medicaid funding.

The Governor has proposed new method of structuring the reimbursement rates for Residential Care Homes. As a representative of non-profit Residential Care Homes (RCH) serving older, we are optimistic about this proposal which will recognize and separate out the personal care services provided to RCH residents from the current daily rate and establish them as Medicaid covered services. This will allow the state to receive federal matching funds on that service portion of the reimbursement. Traditionally funded through State Supplemental funds, this will be the first time the State will receive any federal funding on these expenditures and a portion of the State's savings (25%) is promised to be reinvested into the RCHs.

This policy change shows a confidence in this model of community-based living and reaffirms its crucial role in the continuum of aging services. We are hopeful that the ability to access federal funding for the RCH sector will encourage its growth and help existing providers maintain and improve their physical plant as well as keep up with the costs of providing room, board and services.

We are, however, cautious in our optimism as we do not yet know the details of this new rate structure or what the impact will be on the current reimbursement for existing homes. We therefore ask that safeguards, such as a stop-loss provisions, be put in place if necessary, so that residential care homes are not negatively impacted in the transition.

We will want to know if there will be just one base rate for the services and if additional rates will be offered for individual services such as medication administration. We are also interested in the reinvestment plan for the additional funding and hope to provide input into that decision-making process. And finally, we are aware that many of the providers are small and unfamiliar with the Medicaid billing process and therefore assistance and training in this area would be welcomed.

We ask that the state legislature remain involved in the transition so as to advocate for the residential care home residents and providers. These homes are an important part of the long-term services and supports continuum and we are hopeful that this new rate structure will provide the additional resources needed to support and expand this affordable community based residential option.

Home and Community Based Services

The Connecticut Home Care Program for Elders (CHCPE) is the heart and soul of our state's rebalancing plan when it comes to providing home and community-based aging services. It is this program that helps eligible clients over the age of 65 who are in need of long-term services and supports remain at home. It is also the program that assists many older adults who return to home through the Money Follows the Person Program. *That is why it is vital that we continue to invest in this program and in the provider network that delivers the services and supports.*

Many providers are finding it more and more difficult to serve clients enrolled in this Medicaid waiver program. The rate structure for these services is not sufficient to meet the costs of providing the services and so many providers must restrict the number of waiver clients they serve. On September 1, 2020, most of the providers in the Connecticut Home Care Program for Elders received a 2.3% rate increase in response to the increase in the state's minimum wage. On January 1, 2019, the providers in the Connecticut Home Care Program for Elders received a 2% rate increase that was to be directed toward employee wages. On October 1, 2019 they received a 1% increase, again directed toward wages and benefits. Prior to this, the last increase was 1% in 2015.

The Department of Social Services is currently undertaking a study of the rate methodology used to establish the existing fee schedule for the home and community-based services provided through the Connecticut Home Care Program for Elders. This study is being conducted at the request of the Centers for Medicare and Medicaid Services (CMS). We urge the state to utilize the results of this study to update the current fee schedule by raising the rates to levels that will meet the cost of providing the services. We then propose that the state initiate an annual cost of living rate increase for these home and community-based services. This worthy investment will work to build a strong network of home and community-based providers that is needed to achieve a successfully rebalanced system of long-term services and supports.

Community based providers are meeting the growing needs of Connecticut's older adults and their caregivers while preventing or delaying placements in skilled nursing facilities and helping to prevent the need for more expensive health care settings such as emergency rooms and acute care hospitals. The latest available annual report of the Connecticut Home Care Program for Elders describes the savings that are generated by use of the program as an alternative to nursing home care. These community-based services should be encouraged and we ask for your continued support.

Unlike the unlicensed providers in the Connecticut Home Care Program for Elders, licensed home health agencies have not received a basic Medicaid rate increase for skilled services in twenty years. The inability of the rate structure to keep up with the cost of provider services is causing many agencies to consider limiting their Medicaid case load and this is not the outcome we want to see. As a state that is working vigorously to balance our system of long-term care, we must invest in our licensed home health care network so that older adults can maintain the ability to choose to live and receive skilled nursing services in their home.

The rebalancing process is working. More of our elderly are being cared for in the community. We must not stop now. We urge the state to work with us and the other dedicated stakeholders to continue this progress.

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